

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036875

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8821

STATE FILE NUMBER

FILED SEP 24 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN ST. LOUIS MO

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MO

b. COUNTY

Inside Limits

Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION BETHESDA HOSPITAL

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS 3943 - BLAINE (If outside, give location)

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)First MIDDLE Last
EDWARD B. WILLIAMS

4. DATE OF DEATH

Month Day Year
SEPT. 11 1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

MAY 26 1902

9. AGE (last birthday)

60

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLASSIFIER

10b. KIND OF BUSINESS OR INDUSTRY

ST. LOUIS SUPPORT CENTER

11. BIRTHPLACE (City and state or country)

MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

WILLIAM WILLIAMS

13b. MOTHER'S MARDEN NAME

ANN Mc DANIEL

14. NAME OF HUSBAND OR WIFE

IVA WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

YES WARI

16. SOCIAL SECURITY NO.

[REDACTED]

17. INFORMANT

3 BRYAN WILLIAM 2714 ACCOMAC

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

Cerebral thrombosis
2 day postmortem
4201

INTERVAL BETWEEN ONSET AND DEATH

No

yes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Jan 1 - 62, to Sept 8th and last saw her alive on Sept 8 - 62
Death occurred at Sept 6 - 62 3 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Dr. S. Pyne M.D.

22b. ADDRESS

27529 Chamber

22c. DATE SIGNED

9-15-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

SEPT. 13 1962 LAUREL HILL Cem.

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

ST. LOUIS MO

(State)

24. FUNERAL DIRECTOR

ADDRESS

Thomas Kutas 2906 Grace

25. DATE RECD. BY LOCAL REG.

9-12-1962

26. REGISTRAR'S SIGNATURE

Loan Smith. M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or, by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Ja. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Grandis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.